TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Bone and Joint Center

Respondent Name
Wal Mart Associates Inc

MFDR Tracking Number
M4-16-0873-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
December 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In order to be sure that the patient is in compliance with the treatment plan as set up for him/her and in compliance with the Official Disability Guidelines, it is our protocol of care to perform random drug screens at and intermediate risk level. Which the ODG states a 3-4 time a year frequency is recommended for patients at intermediate risk."

Amount in Dispute: $3,441.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on December 7, 2015. 28 Texas Administrative Code 133.307 (d)(1) states, "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." As no response was received, this dispute will be based on available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 15, 2015	Urinary Drug Screens	$3,441.03	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the billing requirements for professional medical services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 96 – Non-covered charge (s)
   - 582 – Based on Medicare schedule, status indicates this code is either an invalid or delete CPT/HCPCS code. Medicare used another code for reporting of, and payment for, this code. Please re-submit the appropriate code to ensure accurate processing.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 583 – "Based on Medicare schedule, status indicates this code is either an invalid or delete CPT/HCPCS code. Medicare used another code for reporting of, and payment for, this code. Please re-submit the appropriate code to ensure accurate processing." 28 Texas Administrative Code §133.20(b) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

Review of the submitted medical claims finds as follows:

Date of Service	Submitted Code	Status Code
April 15, 2015	80346	I – Not valid for Medicare purposes
April 15, 2015	80361	I – Not valid for Medicare purposes
April 15, 2015	80364	I – Not valid for Medicare purposes
April 15, 2015	80336	I – Not valid for Medicare purposes
April 15, 2015	80368	I – Not valid for Medicare purposes
April 15, 2015	80370	I – Not valid for Medicare purposes
April 15, 2015	80373	I – Not valid for Medicare purposes
April 15, 2015	80372	I – Not valid for Medicare purposes
April 15, 2015	80367	I – Not valid for Medicare purposes
April 15, 2015	80324	I – Not valid for Medicare purposes
April 15, 2015	80365	I – Not valid for Medicare purposes
April 15, 2015	80356	I – Not valid for Medicare purposes
April 15, 2015	80348	I – Not valid for Medicare purposes
April 15, 2015	G0434	Claim not in dispute
April 15, 2015	80354	I – Not valid for Medicare purposes
April 15, 2015	80366	I – Not valid for Medicare purposes
April 15, 2015	80332	I – Not valid for Medicare purposes

April 15, 2015	80349	I – Not valid for Medicare purposes
April 15, 2015	80358	I – Not valid for Medicare purposes
April 15, 2015	83992	Not in dispute
April 15, 2015	80359	I – Not valid for Medicare purposes
April 15, 2015	80360	I – Not valid for Medicare purposes
April 15, 2015	80353	I – Not valid for Medicare purposes
April 15, 2015	80355	I – Not valid for Medicare purposes
April 15, 2015	80345	I – Not valid for Medicare purposes

The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.